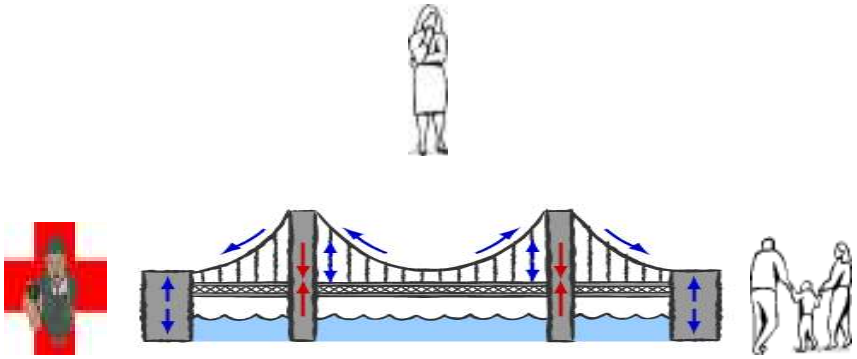
MID-ATLANTIC HEALTH LEADERSHIP INSTITUTE



FAMILY HEALTH NAVIGATOR MODEL

(WITH AN EMPHASIS ON CHILDREN IN A DISPARATE POPULATION IN SUSSEX COUNTY, DELAWARE)

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TABLE OF CONTENTS

INTRODUCTION AND BACKGROUND

The Delaware Mid Atlantic Health Institute (MHLI) Scholars were tasked with identifying an important health issue or initiative and developing a project to address the identified need.

Early in the process the Delaware MHLI Scholars identified the lack of access to health care for poor disparate populations in Sussex County, Delaware. Sussex County has been designated as a medically underserved area and these populations are either underinsured or uninsured.

The Scholars became aware of a new community based group that was formed to address children's health issues in Sussex County and took the initiative to contact the group. In April 2008, the Scholars were invited to attend a meeting of the Sussex County Child Health Promotion Coalition (the Coalition) to hear more about their mission and goals.

The primary mission of the Coalition is "to engage the entire community in a collaborative effort to improve the health of children". Since the establishment of the Coalition, the group has received additional funds from the Delaware Division of Public Health through the PATCH (Planned Approach to Community Health) Grant. This grant has allowed the Coalition to broaden its mission to serve families in the community.

One of the primary goals of the Coalition is to increase the capacity of communities to plan, implement, and evaluate comprehensive, community based health promotion programs targeted toward priority health problems. By working toward this primary goal, the Coalition plans to meet secondary goals that include: improved access to health care for poor families, reduced mortality and morbidity and reduced health care disparities within the community.

There are five critical phases in the Coalition's process:

- Mobilize the community;
- Collect and organize data;
- Choose health priorities;
- Develop a comprehensive intervention plan; and
- Evaluate the outcomes.

The Coalition has already planned and implemented some community events which include food drops and health screenings. Should the health screenings, however, identify abnormal findings, there is no way to follow-up to ensure access to appropriate health care. The Coalition expressed a need for the development of a Family Health Navigator Model to use when writing grant requests for the upcoming year. The Scholars agreed to assist the Coalition in the development of the model.

This project directly relates to the mission and goals of the Coalition, the Delaware Division of Public Health and Healthy Delaware 2010. Should this model be accepted

by the Coalition and be used to apply for grant funds, the Family Health Navigator, serving families in Sussex County, could become a reality in the coming year.

BARRIERS TO HEALTH CARE AND STAYING HEALTHY

Delaware is divided into three counties with Sussex County the most rural.
Studies have shown that working adults living in rural areas are less likely to be offered health insurance through their employer. (2) Employment in rural areas is often through smaller businesses, which employ fewer employees, which in turn causes higher premiums. It is estimated that 20 percent of the American workforce, are employed in businesses with less than 25 employees, but account for 42 percent of American uninsured workers. (2)

Sussex County is also home to a part time seasonal and a migrant population. According to a Centers for Disease Control and Prevention 2004 Survey, additional reasons for the lack of health insurance include losing job or changing employment, employer did not offer insurance or insurance company refused to insure the individual, Medicaid benefits stopped, ineligibility due to age or left school, and change in marital status or death of a parent. (5)

The University of Delaware, Center for Applied Demography and Survey Research, 2006 “Delawareans Without Health Insurance” reported that 12.7% or 105,000 people living in the State of Delaware were without health insurance. Of those, 68% were working adults; 55% were male; 70% were white; 83% were below poverty line; 15% were non citizens; 22% were under the age of 18; and 62% owned or were buying their

own home. Blacks were at a 31% higher risk than whites to be uninsured and 16% of all uninsured were Hispanics. (4)

In Sussex County, the 2006 estimated population was 180,288. The composition of the populations was as follows:

- 83.7% Caucasian,
- 13.8% African American, and
- 6.1% Hispanic or Latino. (1)

A higher percentage of rural residents are also less likely to be seen by a health care provider within the last year and when reporting the state of their health, they report their health as fair – poor. (2) When they do seek health care, a health care provider is likely to see them for an avoidable or preventable condition such as uncontrolled diabetes, pneumonia, or later stages of cancer. (2)

Health insurance is not the only barrier to health care for these vulnerable populations. With the current state of the economy, food, clothing, shelter and transportation take priority over health insurance premiums and health insurance.

The Coalition commissioned Lindy Lewis, PhD, to do a study that would provide information to the Coalition on health priorities for the community. Ms. Lewis used the Planned Approach to Community Health (PATCH) process. The Patch process enabled

the Coalition to identify, plan, and evaluate past and future health promotion and disease prevention community programs. (3)

In January 2008, “Development and Implementation of a Southwestern Sussex Community Health Promotion Project Utilizing the PATCH Process Report of Findings of Efforts to Assist The Community in Identifying Priorities” was submitted to the Coalition. (2) Focus groups and Community Leader Survey tools were used to gather information for the report.

The report included the following issues and concerns:

- Obesity
- Hypertension
- Diabetes
- Sexually Transmitted Diseases
- Reproductive Health
- Co-payment for insurance premiums and prescription medications

Major concerns were identified as lack of resources, lack of knowledge on how to access resources, and navigating the health care system. (3)

The health care system is confusing, expensive, unreliable and impersonal. Too many insured people find it too difficult to navigate the tangle of insurance benefits, eligibility requirements, referral protocols, various levels of care and the bureaucratic maze. The health system is similar to a patchwork quilt – made up of doctor’s offices, group

practices, clinics, hospitals, outpatient services, public health, various payment systems, etc.

The disparate underserved populations in Sussex County experience barriers, not only in access to health care but to staying healthy as well. These barriers include:

Barriers to staying healthy

- Hazardous living and working conditions;
- Knowledge, skills and resource gaps;
- Fragmented service delivery;
- Unemployment;
- Financial problems;
- Inadequate housing; and
- Inadequate nutrition.

Barriers to health care access

- Shortage of health care professionals in the low income and rural communities;
- Inadequate resources (e.g. clinics);
- Lack of access to employer-funded or affordable health insurance;
- Service fragmentation;
- Limited means for out-of-pocket expenses;
- Cultural differences with providers (this is a diverse population which does not readily acclimate or seek public assistance);
- Language differences (there are various languages and dialects);
- Transportation difficulties (public transportation is limited or non-existent);

- Lack of child care;
- Isolation;
- Illiteracy; and
- Gaps in medical coverage.

These identified barriers make it imperative that the Coalition: identify innovative ways to utilize existing resources; make it easy for people to ask for and receive information; access targeted families with creative messages; partner with established agencies and organizations; and foster collaboration with the community. One way to accomplish this is through the use of a Navigator.

BREAKING DOWN BARRIERS

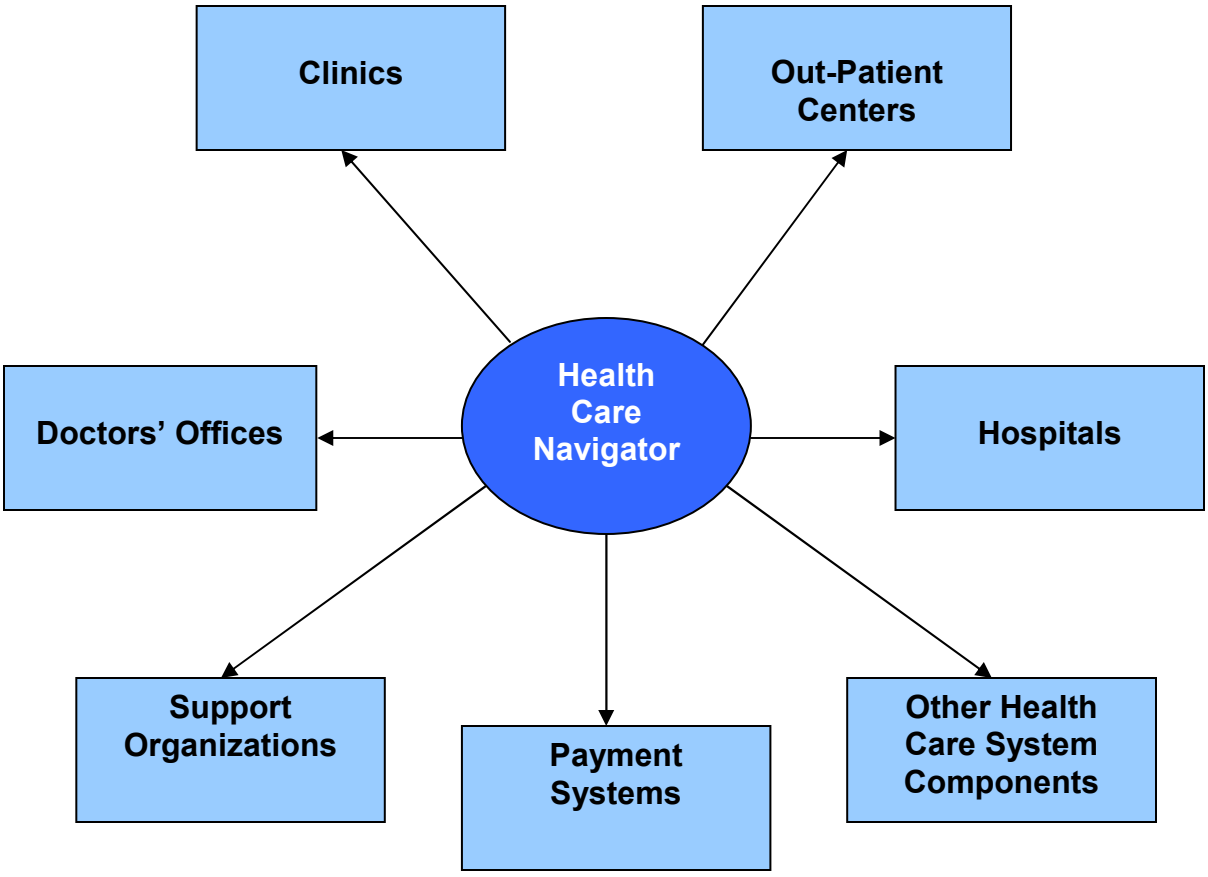
THE ROLE OF THE NAVIGATOR

Patient navigation is one community intervention that has great potential to decrease incidences of disease and save lives. The Sussex County Health Care Navigator role would be multifaceted in terms of providing health care assistance to families.

The immediate role of the Navigator would be to assist families into the local health care system when a health screening demonstrated an abnormal finding. Since numerous barriers to receiving timely diagnosis and treatment exist for this underinsured and uninsured population, the Navigator would need to assure that the individual with an abnormal health finding received timely diagnosis and treatment. The Navigator would accomplish this and improve the quality of care for underserved patients by:

- Providing guidance through the complex medical maze;
- Helping with paperwork;
- Providing transportation to appointments;
- Identifying local resources;
- Communicating effectively with health care professionals; and
- Providing emotional support and encouragement.

The Navigator would be at the center of the hub in assuring the coordination of services for the patient as illustrated by the following diagram:



The Navigator also plays a very important role in community outreach. Through an extensive outreach program, the Navigator can bridge the gaps between a diverse population and a complex health care system while improving the cultural competency of health care providers. Outreach may include attending community organization meetings, meeting with faith based organizations and leadership, and providing information and literature to health care providers.

Finally, the Navigator would provide educational programs that inform disparate populations about the need for screenings to detect existing health concerns. It is critically important that the Navigator be culturally sensitive to the people of the community being served, be able to communicate well and provide follow up information as requested by the community.

The overarching goal of the Navigator model is to improve access to and use of preventive health care for families. Preventive health care would empower families to take a more knowledgeable role in the many and various aspects of their health. The program's aim is to also build trust, improve communications, and promote better health outcomes by increasing cultural competence of health care providers. Through this community partnership (the Coalition, the Navigator, the families, and the providers) a long term goal of lower health care costs may be realized.

"The Navigator wears many hats -
case manager, patient advocate, and most of all – guardian angel."

THE NAVIGATOR MODEL

There is no common definition of patient navigator and the profile of a patient navigator varies widely by program. Most patient navigator models seem to concentrate on a specific disease entity. Once a patient is diagnosed with cancer, for example, the patient may be connected to a patient navigator to help them through the various doctor's visits, treatments, etc. There are few models developed with the intent to reach disparate populations, assist them through the maze of health care, educate them regarding their health and the health care system and empower them to take control of their own health.

While there is currently no set educational requirement for a patient navigator, successful programs have similar characteristics some of which are:

- A Bachelors Degree in Health Science or related field; or health certification as a community health worker plus 2 years experience working in a health care setting or equivalent combination of education and experience.
- Ability to read, analyze and interpret common medical and technical information and documents.
- Ability to effectively present information to others, to impart knowledge and develop critical reasoning to enable healthy decision making.
- Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
- Knowledgeable about the environment and health care system.

- Connected with critical decision makers inside the system.

All of the stated characteristics are essential to the successful development of a patient navigator program for Sussex County. The MHLI Scholars recommend a registered nurse with a Bachelor of Science in Nursing degree as the Navigator of choice for the Sussex County program.

In the first year of the program, the selected Navigator would attend the Harold P. Freeman Patient Navigation Institute at the Ralph Lauren Center for Cancer Care and Prevention. The patient navigator program at the Ralph Lauren Center was pioneered by Dr. Freeman. Dr. Freeman is the President and Founder of The Ralph Lauren Center for Cancer Care and Prevention in New York City and Founder of The Harold P. Freeman Patient Navigation Institute. The Institute offers the only certification program that exists in patient navigation training. The program has created standards and principles that can be tailored to each community's specific needs.

After completion of the Institute training, the Navigator will:

- Develop a plan for meeting and creating partnerships with health care providers in the community.
- Attend community events to meet the various community populations and build a relationship with those underserved populations that will be targeted by the program.

- Educate health care providers regarding cultural needs of the communities being served.
- Educate the community regarding health conditions and the health care system.
- Identify community leaders that would become Community Health Workers and would be able to assist the Navigator in breaking down the barriers to health care.
- Develop a curriculum for Community Health Worker training to be conducted by the Navigator.

The Sussex County Model will utilize a paid trained Navigator during the first year of the program. During this first year, the Navigator will expand the program to include volunteer Community Health Workers. Community Health Workers will have trusted ties to the local community and posses the linguistic and cultural skills needed to connect with patients from underserved communities and the health care system. Delivering direct services (education, advocacy, social support, etc) to vulnerable and underserved consumers in their homes and community settings will often be necessary.

While the lesson plans for the training of Community Health Workers will be developed by the Navigator, the curriculum must include the following to be truly successful:

<u>Lesson Plans</u>

- What is a Community Health Worker?
    - What can I do?
    - Examples of Outreach activities

- Cultural Diversity and Awareness
    - Define culture
    - Define diversity
    - Maintaining cultural sensitivity
    - Understanding how your culture affects you
    - Role of the cultural broker universal communication skills
- Introduction to disease prevention
    - Understanding prevention
    - Understanding consumer role in prevention
    - Understanding chronic infectious disease
- Assessment & Referral
    - How to assess
    - Helping to establish priorities
    - Identifying community resources
    - Identifying physical resources
    - Identifying funding
    - Creating solutions to barriers
- Roles & Boundaries
    - Empowerment v. Enabling
    - Identifying your comfort zones
    - Ethics - professional & organizational
- Confidentiality
    - Protecting the privacy of consumers

- Responsibilities as a Community Health Worker
- Understanding HIPAA

- Communication Skills
  - Verbal
  - Written
  - Body language
  - Touch
  - What affects the way we communicate
  - Assessing comprehension

- Stress Management
  - Identifying Stress
  - Affects of Stress
  - Symptoms of Stress
  - Assessing your own Stress
  - Promoting healthy stress relievers

<u>Learning Outcomes for Community Health Worker Training</u>

- Demonstrate an understanding of role in the health care delivery system.
- Demonstrate concepts of wellness, health promotion, disease prevention and nutrition for a diverse population.
- Demonstrate an understanding of an ability to respond to cultural and social issues.
- Demonstrate the ability to apply skills in various situations.
- Demonstrate an understanding and awareness of the needs of the community.
- Demonstrate an understanding of the concepts of community outreach and health education.

- Demonstrate the ability to document.
- Demonstrate the use of effective communication skills.
- Demonstrate maintenance of consumer respect and dignity.

Strategies for developing the training for the Community Health Worker

- Knowledge and skills development are promoted through interactive training
- Build in time to practice skills
- Use of culturally appropriate strategies
    - Assess training needs
    - Develop training objectives
    - Select training content
    - Select appropriate training methodologies
    - Plan logistics
    - Design and deliver program
    - Evaluate training
    - Plan for ongoing education
    - Avoid covering too much in one session
    - Allow enough time for activities
    - Consider brochures, game playing, role playing, etc.

It is estimated that it will take approximately two years to fully implement this model in Sussex County.

CHARACTERISTICS OF A SUCCESSFUL PATIENT NAVIGATOR & COMMUNITY HEALTH WORKER MODEL

For this model to work in Sussex County, there are many characteristics that the Navigator and the Community Health Workers should possess. Two characteristics, however, are very important: 1 - they should be skilled at communicating with both the target community, Sussex County, and the health care system; and 2 - they should be wise in the culture of the community as well as the culture of the health care system.

Possessing these characteristics allows the Navigator and Community Health Workers to translate the health care culture for the community and interpret the community needs to the health care providers. The Navigator should be looked at as a valued source of health care information to the community and must have the ability to gain respect and trust from the communities they help navigate through the health care system. A community is more likely to trust and respect a navigator if they feel the navigator is compassionate and sensitive to the community's concerns and fears. The Navigator must be focused on the health care system to be both effective and successful. Knowledge of the surroundings and the health care system through which the patient must navigate, round out the characteristics of a successful navigator. (25)

SUMMARY

Many obstacles prevent or hinder the residents of western Sussex County from accessing health care: a large geographic area, a rural setting, limited public transportation and a limited number of primary care physicians to name but a few. Many of the residents are uninsured or underinsured. Many residents are transient and many are part of a culture that feels more comfortable with familiar cultural health practices than current "modern" health care practices. The primary language used at home may not be English. A recent survey commissioned by the Governor's Consortium on Hispanic Affairs found that 22% of Hispanics, living in Delaware, will not seek medical care because they are not proficient in English. (6)

Because of Sussex County's diverse population it is important to find creative and sustainable ways to connect residents with health care providers.

The Health Care Navigator model is one way that residents in need of health care can connect and travel through the complicated health care system. The needs of the residents may be simple or complex:

- The need to find a place to receive an immunization for a child.
- The need to get flu vaccine for the whole family.
- The need to understand what a diagnosis of diabetes means.
- The need to know why it is important to receive a yearly mammogram.
- The need to know "what do I do now that I have been diagnosed with cancer".

The Health Care Navigator model has the potential to be an important part the health care system in Sussex County, Delaware.

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TEAM EXPERIENCE

The Delaware Team has diverse backgrounds in Public Health and includes: a public health nursing supervisor, a Hepatitis C nurse consultant; a health treatment administrator for school-based wellness programs; a planning administrator for emergency preparedness and an administrator for health facilities licensing and certification. Although each seemed to be aware of the others, we had never really worked together before our assignment to the Mid-Atlantic Health Leadership Institute.

The team quickly bonded after our initial meeting and started immediately working on ideas for a project. We met in person and arranged conference calls to get the project off of the ground. Those who had both the free time and the geographical proximity met with outside interests with whom we were hoping to form a partnership.

We utilized partnerships and the internet to collect information to develop a navigator model for Sussex County, Delaware.

Along the way, however, our team met with many challenges which served to hamper our forward progress but not our spirit. Some of the challenges we experienced included:

- Being flooded out of our office building, having to be placed in an alternate location, being allowed in the flooded building for only a couple of hours after the

flood waters subsided to retrieve anything that was retrievable, and still being displaced today.

- Family emergency illnesses.
- Personal emergency illness.
- Job promotion to a different location and new responsibilities.
- Loss of 40% of the office workforce.
- A hiring freeze.
- Move to a different job location and working out of boxes.

In the long run, we were able to capitalize on each others' strengths and develop a model that we believe will be useful to the Sussex County Child Health Promotion Coalition in applying for a grant and fulfilling their Mission.